

## REPORT OF PHYSICIAN

**Kentucky Teachers' Retirement System**  
**479 Versailles Road**  
**Frankfort, Kentucky 40601-3800**  
**(502) 848-8500**

**THIS FORM MUST BE COMPLETED BY A BOARD CERTIFIED PHYSICIAN**

**Patient's Name**

**Social Security # or KTRS Member #**

**TO THE PHYSICIAN:** This member is applying for a retirement annuity due to total and permanent disability which prevents the performance of his/her job duties for a period of at least twelve (12) months. Please attach reports, statements, and other information regarding examinations that have been performed in the last three (3) years period indicating the patient's physical or mental condition. We also request that you print legibly to eliminate any possible confusion.

**NOTE: Your promptness in completing this form will assist us greatly in evaluating this member's eligibility for disability benefits.**

**~ ALL SECTIONS MUST BE COMPLETED ~**

**NOTE: THIS EXAMINATION MUST HAVE TAKEN PLACE WITHIN THE PAST THREE MONTHS.**

I. History of Disability and Symptoms: \_\_\_\_\_

II. Physical Examinations:      Age: \_\_\_\_\_      Weight: \_\_\_\_\_      Height: \_\_\_\_\_

**Date of most recent exam:** \_\_\_\_\_

General Condition (mental or physical that pertain to disability.)

[illegible]

Blood Pressure: \_\_\_\_\_ Laboratory Tests and Results: \_\_\_\_\_

III. Diagnosis \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IV. Please discuss how the disabling condition(s) would have an effect on the member's job duties.  
(This should include such information as what tasks the member would be unable to perform and what restrictions they would have with regard to their specific job.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

V. Corrective Measures: What specific steps have been taken to correct the medical problem?  
(ie: surgery, therapy, medicines, counseling) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VI. Conclusion and Prognosis:  
1) With the proposed corrective measures, when would you expect this patient to be able to return to work?  
\_\_\_\_\_  
2) In your opinion, would this member benefit from a rehabilitation program? \_\_\_\_\_

VII. You must check the box that reflects your recommendation.

**YOU MUST PROVIDE ALL THE INFORMATION  
REQUESTED BELOW OR THIS FORM WILL BE RETURNED.**

☐ **is disabled** physically and/or mentally to perform his/her job duties. ☐ **is NOT disabled** physically and/or mentally to perform his/her job duties.

**KRS 161.661(10)** states that a member retired by reason of disability shall be required to undergo periodic examinations at the discretion of the board of trustees to determine whether the disability allowance shall be continued. When examination and recommendation of a medical review committee indicate the disability no longer exists, the allowance shall be discontinued.

\_\_\_\_\_, M.D. \_\_\_\_\_, 20 \_\_\_\_\_  
(Signature of Physician) (Date)

\_\_\_\_\_  
(Please type or print physician's name) (Mailing Address)

\_\_\_\_\_  
(Type of specialist) (City, State, Zip Code)